Revised 10-24-80

WORD PROCESSING WORK FORM

Tape# MD24

AR 226 - 1384

TO: EMPLOYEE RELATIONS DEPARTMENT
WORD PROCESSING CENTER - N-12533

FROM: Fayerweather Room: _____ Tel: _____ Date _____

Retain Diskette: Perm. ☐ Other _____

Format: Draft ☐ Final Copy ☐ Spacing: Single ☐ Double ☐ As Shown ☐

Job Title: Pregnancy Outcome Questionnaire Author _____

Previous Author (if Applicable) _____

Special Instruction: _____

Your requested typing is attached. If you desire revision, please note and return to me with this slip. Please keep this sheet with your work.

NOTE: In order to keep our records current, please indicate when tape may be erased by returning this sheet to us with your signature. DO NOT SIGN UNTIL THIS WORK IS NO LONGER NEEDED. WHEN THE TAPE IS ERASED THE WORK WILL HAVE TO BE TYPED AGAIN.

Signature _____

Type output requested: Final Copy ☐ Draft ☐ Corrections ☐ Call when ready ☐

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PLEASE MAKE ALL CORRECTIONS IN RED OR GREEN INK - ON ORIGINAL

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FOR WORD PROCESSING CENTER USE ONLY

Received Date	Received Time	Input Typed	Rev.	Total Pages Printed	Operator	Date & Time (Min.)	Pages Scanned	By
					ml 4-22			

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PREGNANCY OUTCOME QUESTIONNAIRE

CONTAINS

PERSONAL AND CONFIDENTIAL MEDICAL

INFORMATION

CASE # _____

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CASE # ________________

DEMOGRAPHIC

What is your name: ____________________ (LAST) ______ (FIRST) ______ (MIDDLE INITIAL)

What is your social security number? ___ ___ ___/___ ___/___ ___ ___ ___

What is your birth date? ___ ___/___ ___/___ ___ (month / day / year)

What is your relationship to this study? (CIRCLE CORRECT ANSWER)

a. Female Washington Works employee

b. Wife of a Washington Works employee

c. Male Washington Works employee

What is the last grade of school you completed? (CIRCLE CORRECT ANSWER)

Elementary: 1 2 3 4 5 6 7 8

Secondary: 9 10 11 12

College: 13 14 15 16 17 18 19 20+

GENERAL MEDICAL

Have you ever been told by a doctor that you had any of the following medical conditions?

	YES	NO	YEAR	MEDICATIONS GIVEN FOR THIS CONDITION (LIST)
● Anemia				
● Sugar diabetes				
● Thyroid condition.				
● Epilepsy, fits, or other neurological conditions. . . .				
● Kidney or bladder condition. .				
● Liver condition.				
● Any type of cancer				
● Heart condition.				

SMOKING

	Yes	No
Have you ever smoked cigarettes?..................................	☐	☐

Age started?...... ☐ Number years smoked?..... ☐ yrs.

Do you now smoke:

Cigarettes?.. ☐ ☐

How many packs a day? (Check one box below)

less than 1/2	1/2-1	1-2	2 or more
☐	☐	☐	☐

Cigars?.. ☐ ☐

How many cigars a day?......................... ☐

Pipe?.. ☐ ☐

How many pipefuls a day?....................... ☐

If you smoke, do you inhale?...................................... ☐ ☐

If you have given up cigarette smoking, how old were you when you last gave up smoking?..______ yrs.

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OCCUPATION

Have you ever worked outside of the home in any of the following industries, jobs, businesses, or conditions?

	YES	NO	If yes, give dates: from Mo/Yr to Mo/Yr
• Clerical worker			
• Factory worker			
• Physician/dentist/chemist/pathologist			
• Other professional worker			
• Chemical operator in a factory			
• Farmer, farm hand, or field worker			
• Maintenance worker or craftsman			
• Service worker/janitor			
• Construction			
• Painter			
• Textile plant worker			
• Beauty salon hairdresser or beautician			
• Plant where dyes were made or used			
• Surgical operating room			
• Where you worked around anesthetic gases			
• Dusty job			
• Where X-rays were used			
• Where radioactive materials were used			
• Where drugs/medicines were made/packaged			
• Dry cleaning shop			
• Where solvents were used			
• Where degreasers were used			
• Where it was very hot			
• Where it was very cold			
• Where you worked around exhaust fumes			
• Where plastics were made			
• Where you had to wear a respirator			
• Where you worked around fumes/gas vapor			
• Where you worked around mists or sprays			
• Where you worked with lead			
• Where you worked with other metals			
• Where you worked with laboratory chemicals			
• Job involving heavy lifting			
• Job involving continual standing			
• Job involving continual sitting			
• Laboratory/medical/dental technician			

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MENSTRUAL HISTORY

The next few questions are about your menstrual periods. You may feel that some of this is a little personal, but it is very important for us to get a complete picture of your health.

How old were you when you had your first period? ____ years
Are you still having periods at all? a. yes b. no

IF NO,
At what age did you have your last period? ____ years
Did your periods: a. stop naturally?
b. stop due to surgery?
c. stop due to radiation?
d. stop for some other reason?
e. stop for some unknown reason?

IF YES,
About how many days are there from the first day of one period to the first day of your next period? ___ days
About how many days does your period last, that is until the bleeding completely stops?..... ___ days

---

Below is a list of changes that women sometimes notice in their menstrual cycles. Since you were 18 years old, have you noticed any of the following changes in your periods?

	YES	NO
skipping periods.		
irregular periods		
increased flow.		
decreased flow.		
increased pain or cramping.		
someother kind of change.		

MARITAL HISTORY

Do you think you have ever been pregnant? a. yes b. no

IF YES, how many times have you been pregnant? ___ times

Are you now: a. married b. divorced c. separated d. widowed
e. never have been married

	PRESENT HUSBAND	PREVIOUS HUSBAND	PREVIOUS HUSBAND
What is your husband's birth date? (mo/yr) . . .	/	/	/
In what year were your married?.	19__	19__	19__
In what year were you widowed/separated/divor.?.	19__	19__	19__
How many times were you pregnant?.	____	____	____
Have you ever wanted to be pregnant, but were unable to?.	YES NO	YES NO	YES NO
Did you ever see a doctor because you had trouble getting pregnant?.			
Did your husband ever see a doctor because you had trouble getting pregnant?. . . .			

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PREGNANCY OUTCOME

If you have never been pregnant, stop here. Otherwise, please continue.

1. How many live-born children have you had?

   a. ___ None
   b. I have had ___ live-born children. Their dates of birth (month/year) are listed below:

   (1) ___/___ (4) ___/___ (7) ___/___ (10) ___/___
   (2) ___/___ (5) ___/___ (8) ___/___ (11) ___/___
   (3) ___/___ (6) ___/___ (9) ___/___ (12) ___/___

2. Were any of the live-births born with birth defects or malformations?

   a. ___ None
   b. ___ Yes. The dates of birth (month/year) and type of defect or malformation are listed below:

   (1) Date: ___/___ (2) Date: ___/___

   Type, part of body affected: _____ Type, part of body affected: _____

3. How many pregnancies did you have that ended with a miscarriage less than 20 weeks after you became pregnant?

   a. ___ None
   b. I have had ___ miscarriages. The dates (month/year) that the miscarriages occurred, and the number of weeks pregnant were:

   (1) ___/___ (2) ___/___ (3) ___/___ (4) ___/___
   ___weeks ___weeks ___weeks ___weeks

4. How many pregnancies did you have that ended in a stillbirth 20 weeks or more after you became pregnant?

   a. ___ None
   b. I have had ___ stillbirths. The dates (month/year) that the stillbirths occurred and the number of weeks pregnant were:

   (1) ___/___ (2) ___/___ (3) ___/___ (4) ___/___
   ___weeks ___weeks ___weeks ___weeks

5. How many pregnancies did you have that ended with a therapeutic or induced abortion (an abortion performed for medical or personal reasons)?

   a. ___ None
   b. I have had ___ abortions. The dates (month/year) and number of weeks pregnant are listed below:

   (1) ___/___ (2) ___/___ (3) ___/___ (4) ___/___
   ___weeks ___weeks ___weeks ___weeks

6. Are you pregnant right now. a. ___ no b. ___ yes: how many months? ___ month

7. Are there any conditions or diseases that repeat in your family?

   a. ___ no b. ___ yes IF YES, describe the condition: _____

8. Are there any conditions or diseases that repeat in your husband's family?

   a. ___ no b. ___ yes IF YES, describe the condition: _____

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PLEASE COMPLETE THE TABLE BELOW. REPORT ON PREGNANCIES IN THE ORDER IN WHICH THEY OCCURRED.

Pregnancy	Pregnancy outcome: live-birth, stillbirths, miscarriage, or abortion (specify)	Date of live-birth, stillbirths, miscarriage, or abortion (month/year)	Illness with a rash or fever? YES	NO	Accidents, injuries or falls YES	NO	Worked outside of home? YES	NO	X-rays taken? YES	NO	Number of cigarettes smoked per day
1		__/__									
2		__/__									
3		__/__									
4		__/__									
5		__/__									
6		__/__									
7		__/__									
8		__/__									
9		__/__									
0		__/__									
11		__/__									
12		__/__									

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Pregnancy	Number of alcoholic drinks consumed per week	Type of birth control method practiced during the 12 months prior to pregnancy (Pill, IUD, diaphragm, other, none)	Type of medications/drugs taken during pregnancy (choose from list in lower right of page)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

- aspirin
- anti-nausea pills
- cold pills
- antihistamines
- diet pills
- artificial sweetners
- diet drinks
- antibiotics
- sleeping pills
- nerve medication
- tranquilizers
- medicines to prevent miscarriage
- diuretics or water pills
- tylenol
- other pain killers
- vitamins
- other medications (specify which one)

For each live born child, please complete the table below:

Child	Birth date (Month/year)	Sex (M or F)	Doctor said baby was early, late, or on-time	Birth weight (pounds/oz.)	Birth length (inches)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

If any of your children were born with a birth defect or other problem, does anyone else in your family have a similar problem?

a. ___ No b. ___ Yes IF YES, please complete the table below:

Child	Child's birthday (month/year)	Child's problem	Family member's problem
1	/		
2	/		

Have you ever been told that you had a hereditary or genetic problem?

a. ___ no b. ___ yes

IF YES, please describe the condition:

_____

Has your husband ever been told that he had a hereditary or genetic problem?

a. ___ no b. ___ yes

IF YES, please describe the condition:

_____

END OF QUESTIONNAIRE. THANK YOU FOR YOUR COOPERATION.
PLEASE RETURN THIS QUESTIONNAIRE TO _____.

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